

ALLAN G. FITZ, PH.D.
LICENSED PSYCHOLOGIST, #1693

12 BELLWETHER WAY, STE. 223
BELLINGHAM, WA 98225

Phone 360-746-2995

Dear Client:

Welcome to my practice and I look forward to meeting you at our first appointment.

When you come to my office for your appointment, press the check in button for Dr. Fitz on the wall by the reception window. There is a sign that helps direct you to do this. Thank you.

Enclosed you will find:

- **Directions to my office**
- **Intake form** – Please complete as fully as possible.
- **Information about your Mental Health Insurance**
- **Agreement / Disclosure** - Please read this form and keep it for your records (required by state law).
- **Notice of Privacy Practices Regarding Protected Health Information**

Thank you for carefully reading and completing these forms. Please bring them with you to our first appointment, as well as your insurance card(s) and picture id.

Sincerely,

Allan Fitz, Ph.D.

Directions from I-5 Southbound

- Exit **Bellis Fair/Meridian (Exit 256)**
- Turn left onto McLeod Road, and then turn right onto Meridian
- Go to second light and turn right onto Squalicum Parkway
- Continue all the way to the Harbor and as road goes under the railway bridge it turns sharply to your left and turns into **Roeder Ave.** Continue on Roeder Avenue to **Bellwether Way.**
- Turn right onto Bellwether Way
- Proceed to four-way stop sign.

You may either drive straight thru the four-way stop and park on the street, or turn left and park in the gravel lot, or turn right and then immediately left into the underground parking garage. As you are driving towards the Bellwether Hotel, we are located on the left side of the road right after the four-way stop in the **Bayview Center Building.** From the parking garage take the yellow elevators to the 2nd floor. From the ground level enter thru the front of the Bayview Center Building and take the elevator to the 2nd floor. We are in Suite 223.

Directions from I-5 Northbound

- Exit **Lakeway Drive (Exit 253)**
- Turn right off ramp
- Turn right at the traffic light onto Lakeway Drive.
- Continue on Lakeway Drive which angles slightly left and becomes one way **Holly Street.**
- Stay on Holly Street and continue through downtown Bellingham to **“F” Street.**
- Turn left onto **“F” Street** and cross the railroad tracks.
- Turn right onto **Roeder Ave.** Continue on Roeder Avenue to **Bellwether Way.**
- Turn left onto Bellwether Way
- Proceed to four-way stop sign.

You may either drive straight thru the four-way stop and park on the street, or turn left and park in the gravel lot, or turn right and then immediately left into the underground parking garage. As you are driving towards the Bellwether Hotel, we are located on the left side of the road right after the four-way stop in the **Bayview Center Building.** From the parking garage take the yellow elevators to the 2nd floor. From the ground level enter thru the front of the Bayview Center Building and take the elevator to the 2nd floor. We are in Suite 223.

Directions to my office are also found on my website at allanfitz.com

ALLAN FITZ, PhD
CLIENT INTAKE FORM

Name: _____	DOB: _____	Gender: _____
Mailing Address: _____		
City/State/Zip: _____		
Phone: Home _____	Cell _____	Other _____
<small>Msg. OK? YES <input type="checkbox"/> NO <input type="checkbox"/></small>	<small>Msg. OK? YES <input type="checkbox"/> NO <input type="checkbox"/></small>	<small>Msg. OK? YES <input type="checkbox"/> NO <input type="checkbox"/></small>

Referred by: _____ Primary Care Physician: _____

Primary Insurance: _____

Secondary Insurance: _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS / CONTRACT

I hereby authorize Dr. Allan Fitz and his billing service, Billing Advantage, Inc. to release to my insurance companies any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to Dr. Allan Fitz. I acknowledge that I have read or been offered and agree to the enclosed Notice of Privacy Practices. I certify that all the above information is correct and I have read and will subscribe to the payment policy on my practitioner's disclosure form.

Signature

Date

Picture ID: Copied Verified

Important Information about Your Mental Health Insurance

As your provider, my office will file a claim with your insurance company to help you receive any mental health insurance benefits to which you are entitled. Benefit plans can vary from company to company and can even change within the same company over time. Thus, it is important for you to know your benefits before your first scheduled visit. Insurance companies often base the amounts that they will pay toward your treatment on restricted fee schedules related to premium payments and geographical location. Your insurance plan will pay me a set allowed amount for each visit, regardless of what my customary fee may be. There are often set limitations in terms of maximum number of visits to a mental health provider per calendar year. Deductibles and co-payments are typically built into most plans and state law strictly regulates their required payment. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions, and my office will do our best to help you with maximizing your benefits.

My responsibilities to you include:

1. Complete your insurance claim forms and submit them to your carrier.
2. Accept any direct payment from your carrier and keep track of balances.
3. Notify you with a monthly billing statement of any remaining balances that may be your responsibility to pay.
4. My office will help to facilitate claims payment, but we do not have the ability to make your plan pay.

Your responsibilities to my office include:

1. To know your benefits.
2. To provide my office with up-to-date and necessary information concerning your insurance coverage so that we may correctly file a claim at the time of your first visit and at any time changes to your insurance coverage occur.
3. To pay any account balance promptly, including but not limited to, copays, co-insurance, and deductibles not paid by insurance.
4. Some insurance companies pay their benefits to subscribers rather than the provider. If you are paid by your insurance company for any benefits, we ask that you notify the office so that we can make necessary adjustments and correctly bill you for the amount due.

Thank you for choosing my office to provide your care. Please sign this form below acknowledging the responsibilities listed above. My office will keep one copy in your chart and will give you one copy for your own records.

Patient or Insured's Signature

Date

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AGREEMENT/DISCLOSURE STATEMENT

Psychology Services

Qualifications

You are scheduled to be seen by Dr. Allan G. Fitz. Dr. Fitz is a licensed psychologist and graduated with his Ph.D. from Fuller Graduate School of Psychology in Pasadena, California, an American Psychological Association accredited program. He completed his internship and a post-doctoral fellowship at the University of Washington Medical Center in Seattle, WA, with specializations in neuropsychology and geriatric psychology. Dr. Fitz has passed the national written examination and the Washington State Board of Psychology Licensing oral examination. He has worked as a rehabilitation psychologist and neuropsychologist at St. Luke's Rehabilitation Institute in Spokane, Evergreen Hospital Medical Center in Kirkland, and on the medical rehabilitation unit at St. Joseph Hospital in Bellingham. Dr. Fitz has also taught graduate and undergraduate psychology courses at Whitworth College and Seattle Pacific University, and has served on committees of the Brain Injury Association of Washington. He has frequently spoken at community forums dealing with cognitive, emotional, and behavioral issues following Alzheimer's disease, brain injury, and Parkinson's disease. Dr. Fitz currently is in private practice in Bellingham, WA.

Treatment Philosophy

The specific nature of your treatment, as well as the number of sessions required to appropriately address your therapeutic needs will vary depending on the reason for your referral. Typically, patients are referred to me for neuropsychological testing. Neuropsychological testing includes taking tests of general thinking ability, academic skills, language functions, memory, attention, and current emotional functioning. The neuropsychological evaluation is administered by Dr. Fitz and usually takes 4 to 8 hours. This time includes meeting with you (and family if you wish) to get background information, review of records, administration of tests, scoring and interpretation of test results, and writing a report. Feedback and recommendations will be provided to you. More information about this type of evaluation can be found on my website at www.allanfitz.com.

On occasion, Dr. Fitz will also see individuals for counseling, and in these cases on average patients receive approximately 8 to 12 treatment sessions. At times, single session psychological evaluations are also done. Dr. Fitz primarily uses a cognitive/behavioral approach to individual counseling, but this does not exclude the use of other treatment modalities that may be appropriate to your needs. You are asked to actively participate in the treatment process, and if you have any questions about your therapy, you are encouraged to discuss them with Dr. Fitz.

Financial Agreement

Fees are based on a rate of \$150 for an hour of individual, family, or couples' therapy and \$160 per hour for testing. Initial intake interviews are \$210 per hour. Dr. Fitz will bill your insurance company for your sessions and will collect co-pays from you. Dr. Fitz will be paid by the insurance company for covered services. Your insurance plan will pay a set allowed amount for each visit, regardless of what his customary fee may be.

Please note that as the recipient of services, you are responsible for all charges not paid for by your insurance company. Payments will be due at the time the insurance company notifies us of any unpaid portion. Please contact your insurer if you have any questions about the details of your plan.

All insurance companies require that your diagnosis be given to them before they agree to pay for services. If you ask, you will be informed of the diagnosis that will be submitted to your insurance carrier. If you have any questions about billing issues, please contact Dr. Fitz or his billing service, Billing Advantage, Inc. at 855-210-3294.

Cancellations

In the event you are unable to keep an appointment, please notify Dr. Fitz at least 24 hours in advance. If such advance notice is not received, you will be responsible for paying a \$50 missed appointment fee. Your insurance will not pay for missed sessions. If your need to cancel or reschedule, you can leave a message on Dr. Fitz's voice mail at (360) 746-2995. Also, please remember to leave your phone numbers with every message if you want Dr. Fitz to return your call.

Emergencies

If you have an urgent situation between counseling sessions, Dr. Fitz may be reached at 360-746-2995. If Dr. Fitz cannot be reached, please call the 24-hour Care Crisis Line at 1-800-584-3578. In the case of an emergency, please call 911 or go to the Emergency Room at your local hospital.

Client Rights

All clients have a right to refuse any recommended service or treatment and/or to request a referral to another agency. Dr. Fitz would be happy to assist you if this becomes an issue. You are also encouraged to ask any questions that may arise during the course of your treatment.

Confidentiality

Anything discussed in therapy, with a few exceptions, is confidential and can be discussed with others only with your signed consent. If you have any questions about confidentiality issues, please discuss them with Dr. Fitz.

A copy of the Notice of Privacy Practices is provided in your packet. If you have any questions about this policy, you can discuss them with Dr. Fitz.

Complaints

If at any time or for any reason you are dissatisfied with the services you receive, please let Dr. Fitz know. If he is not able to resolve your concern, you may report your complaint to the Examining Board of Psychology, Department of Health, P.O. Box 47869, Olympia WA 98504-7869, ph (360) 236-4928.

Relationship with you

Dr. Fitz is an independent practitioner. All treatment decisions remain with you and Dr. Fitz as the client and psychologist.

Notice of Privacy Practices Regarding Protected Health Information

To our clients: We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your **Protected Health Information (PHI)** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By signing this form, you are giving consent for us to disclose your PHI to other outside entities for the following purposes:

- **Treatment:** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.
- **Payment:** obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.
- **Health Care Operations:** activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization

Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an **Authorization Form** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your Psychotherapy Notes—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

We do not release your private health information for marketing or as part of a sale of information. (In situations where that do happen, your authorization would be required.)

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to believe that a child has been abused or neglected, she/he is required by law to report it to the proper law enforcement authorities.
- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that a vulnerable adult has been abandoned, abused, financially exploited, sexually or physically assaulted or neglected, she/he must immediately report it to the appropriate authorities.
- **Health Oversight:** If the State Department of Health subpoenas your therapist or your PHI as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This does not apply when you are being evaluated for a third party or for the court.)
- **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** If we are treating you under a worker's compensation claim, we **must make** all mental health information in our possession that is relevant to the injury **available** to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

- ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).
- ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.
- ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.
- ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.
- ***Right to opt out of receiving fundraising communications.***
- ***Right to restrict disclosure*** of your private health information to a health plan when you have paid out of pocket, privately, for the health service.
- ***Right to be notified*** if there has been a breach of your protected health information.

V. Therapist's Duties

- We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

VI. Complaints

If you have a complaint about the way your privacy rights have been handled, you may contact Dr. Fitz who is the privacy officer for his practice, at 12 Bellwether Way, Suite 223, Bellingham, WA 98225. Phone 360-746-2995.

You may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. Phone 877-696-6775.